HIV Prevention and Primary Care for Transgender Women in a Community-Based Clinic

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Male-to-female transgender individuals, or transgender women (TW), are at high risk for HIV infection and face multiple barriers to HIV care. Advocates agree that numerous factors need to be addressed concurrently to prevent HIV infection in TW, including primary health care. This article examines how a community-based clinic that offers free or low-cost care addresses the health care needs of TW. A total of 20 TW who attended a health care clinic dedicated to community-based health were interviewed regarding best practices for HIV prevention and primary care. In-depth interviews were conducted, transcribed, coded, and analyzed. Factors reported to be effective for HIV prevention and primary care included (a) access to health care in settings not dedicated to serving transgender and/or gay communities, (b) a friendly atmosphere and staff sensitivity, and (c) holistic care including hormone therapy. Community-based health care settings can be ideal locales for HIV prevention and primary care for TW.

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The term *transgender* refers to a diverse group of people including male-to-female or transgender women (TW), female-to-male or transgender men (TM), bi-gender (i.e., persons who identify with both male and female characteristics), and individuals who may or may not cross-dress, undergo sex reassignment surgeries, and/or access hormone therapy (Bockting, Rosser, & Scheltema, 1999a, 1999b; Clements-Nolle, Marx, Guzman, & Katz, 2001; Kenagy, 2005). The gender identity of transgender individuals does not correspond or conform to the gender assigned to them at birth (Sausa, 2003). For example, someone assigned male gender at birth may choose to use the term *woman* to identify herself or may use the term *transsexual*; in both cases, this individual would be classified as transgender. The term *transgender women* is used in this report for reasons of clarity and also as a reflection of many study participants' self-identification as women.

HIV infection has been reported by several researchers to be high among TW (Clements-Nolle et al., 2001; Kellogg, Clements-Nolle, Dilley, Katz, & McFarland, 2001; Kenagy, 2002; Nemoto, Luke, Mamo, Ching, & Patria, 1999; Nemoto, Operario, Keatley, Han, & Soma, 2004a; Risser & Shelton, 2002; Simon, Reback, & Bemis, 2000). A metaanalysis of 29 studies that reported HIV rates for TW showed that self-report of HIV infection was 11.8% (Herbst et al., 2008). In a metaanalysis of studies that reported HIV incidence through laboratory

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testing, 27.7% of TW participants were reported to be infected with HIV (Herbst et al., 2008). Additionally, researchers have noted a decreased use of highly active antiretroviral therapy among HIV-infected TW (Melendez et al., 2006). Evidence has suggested that TW of color are at increased risk for HIV infection (Clements-Nolle et al., 2001; Nemoto et al., 1999; Sausa, 2004). Herbst et al. (2008) showed that racial and ethnic disparities were present among TW; half (56.3%) of all African American TW who were tested for HIV were infected, and Hispanic TW had an HIV infection rate of 16.1%.

Multifactor Concerns of Transgender Women

Research on transgender individuals has primarily focused on select issues surrounding transgender health care such as gender reassignment procedures (Abraham, 1998; Becker et al., 1998), mental health (Barber, 2003; Jones & Hill, 2003; May, 2002; Medeiros, Seehaus, Elliott, & Melaney, 2004; Nuttbrock, Rosenblum, & Blumenstein, 2002), and HIV risk and infection (Bockting, Robinson, & Rosser, 1998a, 1998b; Bockting et al., 1999a; Clements, Wilkinson, Kitano, & Marx, 1999; Kenagy, 2002; Kenagy & Hsieh 2005; Namaste, 1999; Nemoto et al., 1999; Nemoto, Operario, Keatley, Han et al., 2004; Nemoto, Operario, Keatley, Oggins, & Villegas, 2004). The concerns faced by TW render the examination of isolated health issues inadequate and ineffective in improving the overall health of TW. Given the multiple health issues that impact TW, an ecological approach to health care may best reflect their needs—an approach that simultaneously addresses multiple issues at multiple levels.

Researchers have explored myriad factors that lead to increased HIV rates (Herbst et al. 2008). Mental health is an important area to consider in HIV prevention. One study reported that 38% of TW in Washington, DC had suicidal thoughts (Xavier, Robbin, Singer, & Budd, 2005). Violence is also a major health concern among transgender individuals and has been reported to be closely linked to mental health and HIV risk (Clements-Nolle et al., 2001). In a study of TW in San Francisco, 59% of the participants ($n = 392$) experienced forced sex or rape (Clements-Nolle et al., 2001). Research has also shown that substance abuse is a problem of significant magnitude among TW and is strongly associated with high risk sexual behaviors (Bockting et al., 1998a; Clements-Nolle et al., 2001).

Access to Comprehensive Care

Studies have been consistent in reporting both high rates of HIV and the need for health care services for TW on a number of fronts. Because of the economic hardships faced by TW (Asthana & Oostvogels, 1993; Bockting et al. 1998a; National Coalition for LGBT [lesbian, gay, bisexual, & transgender] Health, 2004), community-based health clinics that offer free or low-cost health care may be ideal locations for the health care of TW. However, community-based clinics face a number of challenges in the care of TW clients.

Comprehensive HIV prevention efforts require not only primary care but also consideration of a number of health-related issues that affect TW. Health care advocates argue that only a comprehensive approach to TW needs can begin to curb the high rates of HIV infection in this population. However, the task of providing HIV prevention services and primary care is not easy. Health care clinics must address a number of factors in addition to HIV to curb the spread of HIV infection; these include the following:

1. Access to care including low-cost or free care for transgender individuals who may not be able to afford health care, as well as access to hormones and other gender reassignment procedures (National Coalition for LGBT Health, 2004).
2. Care suited for transgender individuals including health care in locations that are welcoming and safe for transgender individuals and that offer information that is pertinent to transgender issues, as well as the provision of care without the stigma attached to gender identity disorder (American Psychiatric Association, 2000; National Coalition for LGBT Health, 2004). These adaptations may include hiring transgender individuals as health care workers.
3. Treatment of mental health issues, including all psychosocial concerns such as gender identity

disorder as well as violence and abuse (National Coalition for LGBT Health, 2004).
4. Substance abuse treatment, including treatment for both drugs and alcohol.
5. Culturally specific health care with recognition that transgender individuals come from a variety of ethnic and cultural backgrounds. Transgender persons may require services in various languages (Dean et al., 2000).

Addressing these issues simultaneously is challenging, especially in the United States, where health care coverage is marked by disparities. Community-based clinics that offer free or low-cost health care provide an alternative for individuals who are without the financial resources to receive medical care. Unfortunately, many clinics struggle for the resources necessary to provide services to clients. To adequately address suggested recommendations, providers must be familiar with the psychological and social issues surrounding transgender identities as well as how these issues affect health care.

Racial and ethnic health disparities further compound issues of gender identity. For example, Latino transgender individuals may face barriers related to language or, for individuals who have undocumented immigration status, fear that accessing care may place them at risk for deportation (Centers for Disease Control and Prevention, 2004). Providing care that is culturally congruent for transgender individuals is a costly and time-consuming task that requires resources and the training of service providers.

Although many health care clinics that serve transgender communities may be aware of the needs of transgender individuals, it is unknown how clinics that do not specialize in transgender care address the health care needs of TW. A number of health clinics serve LGBT individuals (Garza, 2004; Hellman, 2004; Mayer et al., 2001; Medeiros et al., 2004). Whereas providing health services in clinics devoted to LGBT clients is a good response to some of the barriers that transgender individuals have faced over time, there may be additional difficulties in the provision of health services to transgender individuals in LGBT locales. First, LGBT health clinics are not situated in all geographic locations. Second, many TW may not be comfortable revealing gender identity and may prefer to identify as women rather than as transgender. Third, even if they are comfortable revealing gender identity, many TW may prefer to receive care in non-LGBT focused clinics. For example, some transgender individuals of color may feel uncomfortable or unwelcome in LGBT clinics that are perceived as predominantly White (Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Kenagy, 2005). Also, transgender individuals may feel unwelcome or underserved in clinics that provide health care to the broader group of LGBT clients (Broad, 2002; Drescher, 2002). Many transgender individuals may not relate to or wish to be identified with the LGB component of the larger LGBT umbrella term.

Clinics that offer free or low-cost health care may be the only source of care for many transgender individuals who are unable to afford health care and who do not have health insurance. Therefore, the purpose of this study was to examine how a community-based clinic that is not focused on LGBT clients provided culturally congruent HIV prevention services and primary health care to TW in New York City (NYC), New York.

Method

Overview of the Study

This study used a cross-sectional design for data collection and a content analysis approach to data analysis. Data were collected from 20 TW who were clients of a community-based health clinic in NYC. In-depth interviews were used to identify the concerns and needs of TW surrounding HIV prevention and primary health care. Following the work of Farmer (1999), the goal of this study was to obtain information on best practices to improve HIV prevention services and primary health care for TW.

The clinic in which the study was conducted was located in a low-income area of NYC. The clinic did not cater specifically to LGBT individuals but rather had a mission of serving the low-income community at large. The clinic served mainly self-identified Latino and African American clients. The TW clientele reflected the ethnic composition of non-TW clinic clients. At the time of the study, approximately 80 TW were being treated at the clinic. All data collection followed informed consent

procedures approved by the institutional review boards at the New York State Psychiatric Institute and Columbia University.

Recruitment

Participants were recruited by two physicians who worked at the community-based clinic. Transgender clients who came to the clinic for primary care were approached by the physicians and asked if they would like to voluntarily participate in the study. Physicians identified a client as TW if they knew the client had previously been identified as a gender other than the gender with which they currently identified. In most cases, the criteria meant that the client was taking feminizing hormones. The physicians told potential participants that their services at the clinic would not be affected in any way if they chose not to participate in the study.

Interview Procedures

In-depth interviews were semistructured and included questions about participants' lives from the individual's frame of reference (Dowsett, 1996; May, 1997). The interviewer maintained a conversational stance with directed questions. Interviews allowed meanings and interpretations that individuals attributed to their lives and relationships to be understood, which provided an understanding of the participants' points of view and perspectives (May, 1997).

Interviews were conducted in a private office at the clinic on the same day of recruitment. One of three researchers conducted the interviews. Participants could choose to have the interview conducted in either Spanish or English, and 7 out of 20 interviews were conducted primarily in Spanish. Quotes from interviews that were conducted in Spanish were translated into English. Most interviews were 1 hour; however, three interviews extended to 2 hours. At the end of the interview, each participant received a list of referrals for HIV services in NYC, a safer sex packet, and $35 as compensation.

Interview Protocol

An interview protocol guided the interview and covered three areas: gender identity, HIV risks, and health care experiences. The interview protocol ensured that the same topics were covered with all participants. The protocol also allowed for exploration of specific issues raised by individual participants. For example, a typical question asked of all TW participants was, "Tell me about the people in your life who support you." The question was designed for participants to discuss the supportive individuals in their lives; however, the question was also broad enough to lead to follow-up questions that were not in the interview protocol and may not have been asked of all participants. For example, a participant who mentioned that her mother was an important source of support was also asked about her father, with follow-up questions that related to family, growing up, and migration. Unlike structured interviews, interviewers liberally posed probes related to participants' initial responses to general questions.

Data Analysis

Interviews were recorded and transcribed verbatim. Text data were carefully read and systematically analyzed by three PhD researchers to identify recurrent themes. Content analysis guided the coding of the interviews, and was conducted by three researchers (Neuendorf, 2002). To commence analyses of the data, the authors (all fluent in English and Spanish) randomly selected three interviews. From these interviews, a coding schema was developed that included themes relevant to the aims of the study, such as barriers and facilitators to health care. Following Neuendorf's (2002) method, a coding form was created with themes that were derived from the initial three coded interviews. The coding form also had space for new themes that emerged from the data. The remaining interviews were read and coded for major themes. A separate coding form was used for each interview, and quotes from the interview were added under corresponding themes. To account for trustworthiness, the authors met with a colleague who conducts HIV research to discuss discrepancies with codes, and agreement on codes was reached. Quotes were selected for illustrative purposes because of their representation of the overall interview and particular themes.

Results

Three themes emerged from the interview data related to how HIV prevention services and primary care were provided in the community-based clinic: (a) identity issues and tensions with gay male communities, (b) a holistic approach to the provision of health-related services in the clinic, and (c) transgender-focused services. These themes represented how the community-based clinic in which the study was conducted provided valuable health services to TW.

Sample Characteristics

All participants were 18 years of age or older. All but 4 of the 20 participants were Latina. The 4 non-Latina participants identified as African American. Of the 16 Latina participants, 1 was from Central America, 1 was from South America, and the remaining participants were from Puerto Rico. The mean age of the participants was 30.7 years (range = 18-53, *SD* = 9.8). A total of 4 participants self-identified as having HIV infection. All TW expressed desire for and sexual activity only with men. The average monthly income for this sample was $525 (range = $136-$1200, *SD* = $323.2). A total of 6 participants had completed high school, 7 had completed less than 2 years of high school, 6 had completed junior high school, and 1 had a fourth grade education. None of the TW had undergone genital reconstruction surgery, but 5 participants had undergone breast augmentation procedures. A total of 18 participants were currently taking hormones; however, 2 participants had recently lost the ability to pay for hormones.

Identity Issues and Tensions With Gay Male Communities

TW were asked about the terms they use to describe themselves. A large proportion of participants indicated that they did not use the term *transgender* to identify themselves, although they knew what it meant. In describing their lives, participants used the terms *woman*, *transsexual*, and, in a few instances, *drag queen*. One TW participant said, "I don't really identify myself as transgender, even though people say the name *transgender*; I identify myself as a woman. See myself as a woman." Clients may have chosen this clinic for services because they knew that they were not expected to identify as transgender and they also felt free to and were comfortable with identifying as women. These perceptions helped ensure primary health care for TW who may have avoided clinics where their identity was problematic.

TW drew distinctions between themselves and gay men. For example, one participant said, "I don't consider myself gay or transgender. I consider myself a complete woman." Several participants discussed tensions between transgender individuals and gay individuals. In some instances, the label *gay* was considered a serious insult directed at other TW and used to denote a sense of "other" among TW. For example, one participant commented as follows:

> It's just that, in the gay life, there's other gays…that try to put the ones that do the right thing—that go to school, that live at home with their mother, you know—down. Some of them take hormones and live out on the street, and they'll inject anything in them….

Another participant addressed the tensions between TW and gay males.

> We are so hated by gay people. I don't understand it, I don't hate them nor do I see them like that…. I have seen much discrimination of gay people towards transgenders, and they think very horrible things about us.

The comfort of TW at the community-based clinic may have been important for their access to health care. A clinic that does not specify that it caters to transgender or gay communities may in fact feel more welcoming to TW who prefer not to identify as transgender and feel estranged from the gay male community. By removing the barrier of transgender or gay identification, the clinic increased TW attendance and thereby primary care for TW, allowing clinic personnel the ability to then implement HIV prevention interventions with TW.

Transgender-Friendly Services

The services of the clinic became known through word-of-mouth and yielded a network of TW who

met at the clinic. Most participants reported that they came to the clinic because another TW referred them. The TW clientele would meet friends or acquaintances when they came to the clinic and often stayed after appointments to talk with friends. Some came to the clinic when they did not have an appointment to be able to see their friends.

Participants reported that the clinic was a safe place. Of primary importance was the welcoming attitude of the health care personnel and physicians toward the TW clients. Clinic personnel had been well-trained to refer to all TW by their preferred names rather than their legal names, which were often found on official state documents. On this topic, one participant described the clinic as having "a warm atmosphere. It's caring. You can tell that the service providers and the health care providers care. They're interested in knowing what's going on with you." Another participant remarked that at the clinic, "you get everything you need, and not just the medication—you get the love, the care, the concern, the case management, the therapy—you get everything you need right here." Some participants described clinic personnel of other medical establishments as being uncaring. One participant stated, "My personal dealing with them [personnel at other establishments]…it wasn't that friendly. It was like, 'I'm here to do a job, that's what I'm going to do and that's that.'" Many participants reported that clinic personnel who understood their health and social needs and were competent to provide appropriate services were crucial factors in the decision to use clinic services.

It is noteworthy that the clinic focused on serving the Spanish-speaking community. The presence of Spanish-speaking health care personnel was a major motivator for the TW, most of whom were also Spanish-speaking, to visit the clinic. Although the clinic employed some White health care providers and physicians, the majority of personnel working at the clinic were people of color, mainly Latino. The director of the clinic at the time was also Latino.

A Holistic Approach to the Provision of HIV Prevention and Primary Care

One-stop shopping. When discussing the difficulties of having health care needs met, many participants remarked that they appreciated the community-based clinic because they were able to obtain hormones, HIV testing and treatment, and social services as well as general checkups under one roof. Participants described having a variety of health care needs, and the holistic approach to service provision at the clinic was favorably perceived by all participants. For example, one participant was being guided through a smoking cessation program at the clinic and also attended the clinic for hormone therapy. An HIV-infected participant said, "Clinics like here, where you can go and get everything in one…it's a great help." Before she discovered the clinic, this TW had to devote more time and energy to obtaining health care; she elaborated as follows:

> Before I came here, it was like I was a traveling idiot. I mean…to get hormones, I would have to go to Brooklyn. For the HIV care…I would probably have to go to St. Vincent…it was like you would have to go to so many different places to get what you need to keep yourself up, but with a place like here, you're one-stop shop.

The clinic routinely provided HIV testing and screening for sexually transmitted infections (STIs). Physicians also provided information and free condoms. Many TW described how they stopped by the clinic to greet clinic personnel and the TW who were often in the waiting room. During these visits, many TW would pick up free condoms. One participant relayed: "I always have them [condoms], always use them…when I run out, I can get a bunch of them here." Since HIV and STI testing were routine parts of the care TW received, they were more likely to see sexual health screenings as a part of their overall health care rather than as being distinct from the other health services they received. One participant discussed the realization that her partner was having an affair. She said, "Right now, it's [HIV] not coming out, but you never know in 2, 3, 4 months…. I'm going to get my results now." Because she had easy access to the clinic and health care services, this participant did not hesitate to have an HIV test.

Hormone therapy. Hormone therapy emerged as an important subtheme to comprehensive health care services, especially in the care of HIV-infected

clients. To develop a feminine appearance, most TW at the clinic regularly took estrogen. Participants discussed the importance of taking feminizing hormones. All participants desired the feminizing effects that the hormones had with respect to their appearance; however, many also discussed the importance of hormone therapy for their physical safety. For example, one participant described being unable to take hormones for a period of time because of lack of health insurance. She described being unable to leave the house because her facial hair grew back as a result. She explained, "I haven't taken estrogen in 15 days, and look at how I am [pointing to her chin with facial hair]…. I leave the house covered and early to avoid the school boys in my building." Because neighbors identified her as a woman, she feared that some of her neighbors would verbally and physically attack her if they realized she was a TW. Without hormones, many TW grow back facial hair and other masculine features such as muscle mass. The reemergence of these features can be devastating, especially for TW whose social networks may not be aware they are transgender.

HIV care. Many of the TW clients reported that they originally came to the clinic to receive hormone therapy. The clinic physicians recognized that hormone administration was an important component of transgender care. These providers stressed a comprehensive approach to care and suggested that their TW clients also receive HIV and STI testing and treatment as well as general preventive health care. For HIV-infected clients, hormone therapy remained an important consideration. One participant noted that TW who are HIV-infected may not prioritize HIV medications if they have to stop taking feminizing hormones. She explained, "They [other TW] feel that the HIV meds would mess with the hormones, and by them being transgender, they want the hormones to work okay." The clinic made hormone therapy an integrated component of health care. The physicians at the clinic understood the importance of hormones to TW clients, which resulted in TW coming to the clinic for hormone therapy. Additionally, TW clients trusted physicians at the clinic to provide overall care because they did not fear that the physicians would discontinue their hormone therapy.

Discussion

Statements from interviews with 20 TW revealed important considerations for optimizing TW access to HIV prevention and primary health care, especially in relation to community-based clinics that serve low-income racial and ethnic minority populations. The clinic where interviews took place was a good example of a community-based setting that was not specifically devoted to LGBT communities yet committed to providing health care services for TW. Many of the practices at the clinic resulted in HIV prevention by initially attracting TW into a health care setting. After primary care was established, HIV prevention became a routine part of care for many TW clinic clients. A number of factors drew TW to the clinic, including the following:

1. They could identify as women and were not assigned a transgender identity.
2. They had access to health care that accommodated their need to receive hormones.
3. They perceived a caring attitude among clinic personnel and health care providers that created an atmosphere that was conducive to culturally congruent HIV prevention and primary health care.

Identity emerged as an important consideration with regard to access to care for TW. Results reflected a separation of some TW from the umbrella term of *LGBT* and especially gay communities, a trend that has been documented by other researchers (Broad, 2002; Drescher, 2002). Although LGBT health clinics provide valuable services to large numbers of transgender clients, study results illustrate that TW may prefer to not receive services at these clinics. Some TW (a) perceive *gay* as a derogatory term and/or perceive gay individuals as the "other," (b) do not believe they belong to the gay community or feel accepted by the gay community, and (c) do not identify as transgender and may be less likely to seek and receive care at clinics that specialize in serving the LGBT community. By making health care more comfortable for TW and easy for them to access, a number of HIV prevention and primary care services were made available to TW at the general community-based clinic.

Table 1. Connections Between Themes, Interview Data, Clinic Procedures, and Recommendations for Optimal Health Care Services for Transgender Women

Theme	Interview Data	Clinic Procedures	Recommendations
Identity issues and tensions with gay male communities	"I identify myself as a woman. See myself as a woman."	• Clinic personnel used preferred gender identity with corresponding pronoun. • TW are encouraged to identify their preferred gender category, including *woman*. • Clinic personnel treat TW patients with respect, thus encouraging word-of-mouth recruitment of TW to clinic. • Well-trained health care personnel ensure that the clinic is viewed as a safe place by TW patients.	• Clinics should reach out specifically to transgender individuals and must be sensitive to various TW identities, including TW not identifying with any part of the LGBT umbrella term • Word of mouth can be systematically used to increase use of community-based health clinics by TW. • Staff and providers working in community-based clinics need to be continually trained and updated on issues relating to transgender health.
	"I don't consider myself gay or transgender."	• The clinic is open to all rather than specifying a focus on care for LGBT individuals.	
Transgender-friendly services	"They're interested in knowing what's going on with you. They show concern, whereas in some places you go to it's like—'Okay, this is what you're here for, let's do it, let's get it done, that's that.'"	• Clinic personnel were accepting of and compassionate with TW at the clinic.	• Services should include HIV counseling and testing, HIV treatment, hormone therapy, and psychosocial services (e.g., violence prevention, assistance with employment, housing, and immigration).
Holistic approach to the provision of HIV prevention and primary care	"It was like, you would have to go to so many different places to get what you need to keep yourself up, but with a place like here—you're one-stop-shop."	• Clinic personnel provide health and social services under one roof.	• Community-based clinics should consider offering a range of health care and social services to TW.
	"They [other TW] feel that the HIV meds would mess with the hormones, and by them being transgender, they want the hormones to work okay."	• Clinic personnel made access to female hormones a priority, even for HIV-infected clients	• Providers who serve HIV-infected TW need to take into account the psychosocial and safety needs of continuing with hormone therapy and attempt to combine hormone therapy with antiretroviral therapy when advisable.

NOTE: LGBT = lesbian, gay, bisexual, and transgender; TW = transgender women.

Although the clinic did not specialize in transgender care, because clinic personnel and health care providers treated TW with respect, word-of-mouth recruited many TW to the clinic. Most TW traveled long distances to come to the clinic. In many cases, TW traveled for close to 1 hour through a county with several LGBT health care settings. The diversity among TW demands that there be a variety of health care options for them. Results suggested that community-based clinics may be well-suited to provide health care for TW, especially TW of color. However, clinics must employ well-trained personnel who are prepared to provide health care to accommodate the specific needs of TW.

The community-based clinic provided many services under one roof, a fact that also increased attendance of TW at the clinic. Although many TW came to the clinic seeking hormone therapy, they received comprehensive examinations and were counseled to receive HIV and STI tests. The underlying poverty among the TW who attended the clinic and the economic incentives associated with unprotected sex in exchange for drugs or money, as well as the high rates of HIV infection among TW (Clements-Nolle et al., 2001), underscore the importance of HIV testing for all TW. It is also crucial to provide hormone therapy for TW who are HIV-infected and who desire hormone therapy. Provision of hormones may increase interest in the clinic and may provide a means for health care providers to encourage HIV and STI testing, counseling, and treatment. TW need to retain a feminine appearance for their psychological well-being as well as to avoid harassment and violence. Ensuring hormone therapy for TW who desire estrogen may help make HIV treatment more palatable for these TW. Onsite psychosocial support (i.e., support groups, mentoring, social and recreational activities) may also help retain TW in care.

Limitations of this study included the small sample size of TW selected exclusively from one clinic. It is unknown if a select group of TW from the clinic was sampled because participants were recruited by clinic physicians. Therefore, results cannot be generalized to the TW population. However, results suggest areas in which clinics could increase access to HIV prevention and primary care for TW. Many of the clinic practices and procedures can be used as examples for other community clinics (both general agencies and agencies specifically focused on LGBT health) to improve the quality of services for TW, increase the number of TW accessing culturally congruous services, and reduce HIV infection in this population (see Table 1).

The clinic provided an environment that was acceptable to TW. The clinic had properly trained clinic personnel to reach out to TW and provide holistic care. Although the acceptance of transgender individuals in non-LGBT clinics may be challenging, it seemed to be easily achieved in this clinic with proper staff training and compassion. Training materials for health care personnel have been created and are available free of charge on the Internet (see National Coalition for LGBT Health, 2004). Additionally, it was the personal contact with the clinic that motivated TW to tell other TW about the clinic; hence, the clinic built its TW clientele through word-of-mouth. Transgender individuals face immense stigma and discrimination throughout their lives. Finding nonjudgmental, caring, and knowledgeable health care providers is crucial for their health. Practice environments that are safe and welcoming are a vital part of providing culturally congruous health care for TW.

Clinical Considerations

- Community-based clinics that serve general populations can accommodate TW clients.
- Health care staff and administrative personnel should provide a safe and friendly environment for TW.
- HIV prevention and treatment for TW should be embedded in a variety of services that consist of comprehensive, holistic care, including primary care, hormone therapy, mental health services, and, if possible, social services for domestic violence, housing, employment and training, and immigration.

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References

Abraham, F. (1998). Genital reassignment on two male transvestites. *International Journal of Transgenderism*, *2*. Retrieved May 27, 2009, from http://www.symposion.com/ijt/ijtc0302.htm.

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders (4th ed., text revision). Washington, DC: Author.

Asthana, S., & Oostvogels, R. (1993). Communication participation in HIV prevention: Problems and prospects for community-based strategies among female sex workers in Madras. *Social Science Medicine*, *43*, 133-148.

Barber, M. (2003). Mental health issues in lesbian, gay, bisexual, and transgender communities. *Journal of Gay & Lesbian Psychotherapy*, *7*, 77-82.

Becker, S., Bosinski, H., Clement, U., Eicher, W., Goerlich, T., Hartmann, U., et al. (1998). German standards for the treatment and diagnostic assessment of transsexuals. *International Journal of Transgenderism*, *2*. Retrieved May 27, 2009, from http://www.symposion.com/ijt/ijtc0603.htm.

Bockting, W., Robinson, B., & Rosser, S. (1998a). Transgender HIV prevention: A qualitative needs assessment. *AIDS Care*, *10*, 505-526.

Bockting, W., Robinson, B., & Rosser, S. (1998b). Transgender HIV prevention: Qualitative evaluation of a model prevention education program. *Journal of Sex Education & Therapy*, *23*, 125-133.

Bockting, W., Rosser, S., & Scheltema, K. (1999a). Transgender HIV prevention: Community involvement and empowerment. *International Journal of Transgenderism*, *3*. Retrieved May 30, 2009 from http://www.symposion.com/ijt/hiv_risk/bockting.htm.

Bockting, W., Rosser, S., & Scheltema, K. (1999b). Transgender HIV prevention: Implementation and evaluation of a workshop. *Health Education Research*, *14*, 177-183.

Broad, K. (2002). GLB + T?: Gender/sexuality movements and transgender collective identity (de)constructions. *International Journal of Sexuality and Gender Studies*, *7*, 241-264.

Centers for Disease Control and Prevention. (2004). Access to health-care and preventive services among Hispanics and non-Hispanics—United States, 2001-2002. *Morbidity and Mortality Weekly Report*, *53*, 937-941.

Clements-Nolle, K., Marx, R., Guzman, R., & Katz, M. (2001). HIV prevalence, risk behaviors, health care use, and mental health status of transgender persons: Implications for public health intervention. *American Journal of Public Health*, *91*, 915-921.

Clements, K., Wilkinson, W., Kitano, K., & Marx, R. (1999). HIV prevention and health service needs of the transgender community in San Francisco. *International Journal of Transgenderism*, *3*. Retrieved May 27, 2009 from http://www.symposion.com/ijt/hiv_risk/clements.htm.

Dean, L., Meyer, I., Robinson, Sell, R., Sember, R., Silienzio, V. M. B., et al. (2000). Lesbian, gay, bisexual, and transgender health: Findings and concerns. *Journal of the Gay & Lesbian Medical Association*, *4*, 102-151.

Dowsett, G. (1996). *Practicing desire: Homosexual sex in the era of AIDS*. Stanford, CA: Stanford University Press.

Drescher, J. (2002). Transgender inclusion—The widening field. *Journal of Gay and Lesbian Psychotherapy*, *6*, 1-3.

Farmer, P. (1999). *Infections and inequalities: The modern plagues*. Berkeley, CA: University of California Press.

Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. W. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health*, *38*, 230-236.

Garza, D. (2004). The Community Health Project. *Journal of Gay & Lesbian Psychotherapy*, *8*, 97-105.

Hellman, R. E. (2004). Interview with Barbara E. Warren, PsyD, CASAC, CPP. *Journal of Gay & Lesbian Psychotherapy*, *8*, 155-170.

Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., Crepaz, N., et al. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS and Behavior*, *12*, 1-17.

Jones, B. E., & Hill, M. J. (2003). Mental health issues in lesbian, gay, bisexual, and transgender communities: Review of psychiatry. *Journal of Nervous and Mental Disease*, *191*, 132-133.

Kellogg, T., Clements-Nolle, K., Dilley, J., Katz, M. H., & McFarland, W. (2001). Incidence of human immunodeficiency virus among male-to-female transgendered persons in San Francisco. *Journal of Acquired Immune Deficiency Syndromes*, *28*, 380-384.

Kenagy, G. (2002). HIV among transgender people. *AIDS Care*, *14*, 127-134.

Kenagy, G. (2005). Transgender health: Findings from two needs assessment studies in Philadelphia. *Health & Social Work*, *30*, 19-26.

Kenagy, G., & Hsieh, C. M. (2005). The risk less known: Female-to-male transgender persons' vulnerability to HIV infection. *AIDS Care*, *17*, 195-207.

May, K. (2002). Becoming women: Transgendered identities, psychosexual therapy and the challenge of metamorphosis. *Sexualities*, *5*, 449-464.

May, T. (1997). *Social research: Issues, methods, and process*. Philadelphia: Open University Press.

Mayer, K., Appelbaum, J., Rogers, T., Lo, W., Bradford, J., & Boswell, S. (2001). The evolution of the Fenway Community Health Model. *American Journal of Public Health*, *91*, 892-894.

Medeiros, D., Seehaus, M., Elliott, J., & Melaney, A. (2004). Providing mental health services for LGBT teens in a community adolescent health clinic. *Journal of Gay & Lesbian Psychotherapy*, *8*, 83-95.

Melendez, R. M., Exner, T. A., Ehrhardt, A. A., Dodge, D., Remien, R. H., Rotheram-Borus, M. J., et al. (2006). Health and health care among male-to-female transgender persons who are HIV positive. *American Journal of Public Health*, *96*, 1034-1037.

Namaste, V. K. (1999). HIV/AIDS and female-to-male transsexuals and transvestites: Results from a needs assessment in Quebec. *International Journal of Transgenderism*, *3*. Retrieved May 27, 2009, from http://www.symposion.com/ijt/hiv_risk/namaste.htm.

National Coalition for LGBT Health. (2004). An overview of U.S. trans health priorities: A report by the Eliminating Disparities Workgroup, August 2004 update. Retrieved May 27, 2009, from http://www.lgbthealth.net/TransHealthPriorities.pdf

Nemoto, T., Luke, D., Mamo, L., Ching, A., & Patria, J. (1999). HIV risk behaviors among male-to-female transgenders in comparison with homosexual or bisexual males and heterosexual females. *AIDS Care*, *11*, 297-312.

Nemoto, T., Operario, D., Keatley, J., Han, L., & Soma, T. (2004). HIV risk behaviors among male-to-female transgender persons of color in San Francisco. *American Journal of Public Health*, *94*, 1193-1199.

Nemoto, T., Operario, D., Keatley, J., Oggins, J., & Villegas, D. (2004). Social context of HIV risk behaviours among male-to-female transgenders of colour. *AIDS Care*, *16*, 724-735.

Neuendorf, K. A. (2002). *The content analysis guidebook*. Thousand Oaks, CA: Sage.

Nuttbrock, L., Rosenblum, A., & Blumenstein, R. (2002). Transgender identity affirmation and mental health. *International Journal of Transgenderism*, *6*. Retrieved May 27, 2009 from http://www.symposion.com/ijt/ijtvo06no04_03.htm.

Risser, J., & Shelton, A. (2002). *Behavioral assessment of the transgender population, Houston, Texas*. School of Public Health. Galveston, TX: University of Texas.

Sausa, L. A. (2003). The HIV prevention and educational needs of trans youth: A qualitative study. *Dissertation Abstracts International*, *64*, 1186.

Sausa, L. A. (2004). Transgender care: Recommended guidelines, practical information, and personal accounts. *Archives of Sexual Behavior*, *33*, 420-422.

Simon, P., Reback, C. J., & Bemis, C. (2000). HIV prevalence and incidence among male-to-female transsexuals receiving HIV prevention services in Los Angeles County. *AIDS*, *14*, 2953-2955.

Xavier, J. M., Robbin, M., Singer, B., & Budd, E. (2005). A needs assessment of transgendered people of color living in Washington, DC. In W. O. Bockting & E. Avery (Eds.), *Transgender health and HIV prevention: Needs assessment studies from transgender communities across the United States* (pp. 31-48). New York: Haworth Medical.